BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KHURRAM KHAN DURRANI, M.D. Physician's and Surgeon's Certificate No. A 72805, Respondent.	Case No. 800-2016-021897 OAH No. 2018010095

DECISION AFTER NON-ADOPTION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on May 21 and 22, 2018, in Oakland, California.

Greg W. Chambers, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Kevin Mintz, Attorney at Law, Rankin, Sproat, Mires, Reynolds, Shuey & Mintz, represented respondent Khurram Khan Durrani, M.D., who was present.

The record closed and the matter was submitted for decision on May 22, 2018.

On June 21, 2018 ALJ Schneider issued her Proposed Decision. On July 12, 2018, ALJ Schneider issued her Corrected Proposed Decision. Panel A of the Medical Board of California ("Board") declined to adopt the Corrected Proposed Decision issued by ALJ Schneider and on July 31, 2018 issued its Order of Non-Adoption of Proposed Decision and afforded the parties the opportunity for written argument. Panel A fixed the date of oral argument for October 17, 2018. The Panel having read and considered the administrative record and the written arguments submitted by the parties, and having heard oral argument, hereby renders its decision in this matter.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer issued the Accusation in her official capacity as Executive Director of the Medical Board of California, Department of Consumer

Affairs (Medical Board).

2. On August 10, 2000, the Medical Board issued Physician's and Surgeon's Certificate (Certificate) No. A 72805 to Khurram Khan Durrani, M.D. (respondent). Respondent's Certificate was in full force and effect at the times of the acts set forth below and will expire on April 30, 2020, unless renewed.

3. The Accusation alleges that respondent committed unprofessional conduct (repeated acts of negligence and gross negligence, and failure to maintain adequate and accurate medical records) in his treatment of patients D.L. and L.W.[1] Respondent filed a notice of defense and this hearing followed.

4. The standard of proof applied in making the factual findings is clear and convincing evidence to a reasonable certainty.

Expert testimony at hearing

5. The experts who testified at hearing were familiar with the standard of care and laws applicable to the professional conduct of psychiatrists in California. Each expert reviewed pertinent medical records and documents, as well as the transcript from the Medical Board's interview with respondent on December 8, 2016. They each offered an opinion as to whether respondent committed unprofessional conduct in connection with his treatment of D.L. and L.W.

MEDICAL BOARD'S EXPERTS

6. Nzinga Ajabu Harrison, M.D., graduated from the University of Pennsylvania Medical School and completed her internship and residency in psychiatry at Emory University. She received her license to practice medicine in Georgia in 2004. She is Board-certified in adult psychiatry and holds positions at Morehouse School of Medicine (Adjunct Clinical Assistant Professor) and DeBusk College of Osteopathic Medicine (Clinical Adjunct Faculty). Dr. Harrison is also licensed to practice medicine in California. She has worked for Anka Behavioral Health (Anka) for almost five years; her current position is Chief Medical Officer (CMO). Dr. Harrison also has a small private practice.

7. Kenneth S. Chuang, M.D., graduated from Harvard Medical School in 1995. He completed a residency in 1999, and a fellowship in 2000, at the Neuropsychiatric Institute at the University of California, Los Angeles (UCLA). Dr. Chuang is Board-certified in adult psychiatry. Dr. Chuang is an Associate Clinical Professor at UCLA's Medical School, and an attending psychiatrist at the Edelman Mental Health Clinic, Los Angeles County Department of Mental Health. Dr. Chuang is also a medical reviewer for the Medical Board.

[1] The patients are referred to by initials to protect their privacy.

RESPONDENT'S EXPERTS

8. John George Rosenberg, M.D., M.P.H., graduated from the University of California, San Francisco, Medical School in 1982, after having received a master's degree in public health from University of California, Berkeley, School of Public Health. Dr. Rosenberg completed his residency in 1986, at the University of California, San Francisco, Langley Porter Institute. He has practiced psychiatry for about 31 years. He has held positions including Medical Director of various units at Alta Bates Medical Center, and President of the Alta Bates Medical Staff. Dr. Rosenberg is currently a Staff Psychiatrist at the Berkeley Therapy Institute, where he specializes in performing work related to physician impairment.

9. Mark Randall Bloch, M.D., graduated from Dartmouth Medical School and completed his residency at Stanford University Hospital. Dr. Bloch is Board-certified in adult psychiatry. Dr. Bloch is currently in private practice. He also works as a Staff Physician and a clinical faculty member at Stanford University Hospital, and as the Associate Medical Director at the Affiliated Research Institute in Berkeley.

Respondent's background

10. Respondent received his medical degree from Khyber Medical College in Pakistan. He completed a series of four internships, which each lasted six months, in general surgery, internal medicine, dermatology and psychiatry. Additionally, he completed a six-month internship at Edgware General Hospital in London; a six-month externship in psychiatry at Washington Hospital Center, in Washington, D.C.; and, residency and fellowships training at St. Elizabeth's Hospital, Washington, D.C., George Washington University Hospital, Stanford University, and University of California, Los Angeles. Respondent is Board-certified in child and adolescent psychiatry, adult psychiatry, and psychosomatic medicine.

11. Since 2003, respondent has practiced outpatient community psychiatry at the Behavioral Health Services for the County of San Joaquin. He began as a staff psychiatrist, and for the past four years he has held the position of Medical Director. As Medical Director, he supervises 30 physicians. Between 2006 and 2016, respondent was employed by Anka as an independent contractor/consulting physician, where he worked about five hours per week. This is respondent's first disciplinary matter before the Medical Board.

Setting in which alleged misconduct occurred

12. At the time of the alleged misconduct, D.L. and L.W. were patients at Casa Phoenix, an adult mental health crisis residential treatment program that is operated by Anka.[2] Casa Phoenix is located in a residential home and houses six patients. As

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[2] Anka operates a number of residential treatment programs that serve mentally ill and developmentally disabled clients.

Dr. Harrison explained, Casa Phoenix is a "step down from inpatient psychiatric care," and "stands in between inpatient and outpatient" treatment settings.

13. Psychiatric evaluations are conducted in either the downstairs group room or the upstairs administrative office of Casa Phoenix. Because psychiatrists are not expected to routinely perform physical exams, there are no exam rooms or exam supplies, such as gloves and body coverings. Psychiatrists performing psychiatric evaluations are also expected to triage patients, meaning that they assess patients' medical issues and determine the degree ofmedical intervention that is required. Dr. Harrison explained that any physical exams performed as part of the triage process must conform to the standard of care.

14. At the time of the incidents, all Anka patients were Kaiser Permanente (Kaiser) patients and had access to Kaiser medical services. Anka staff was instructed to use Kaiser services, such as the advice nurse, urgent care, emergency care, or a referral to a primary care physician, to address patients' physical health concerns.

15. At the time of the alleged misconduct, respondent was a part-time consulting psychiatrist[3] in several of Anka's facilities, including Casa Phoenix, where he performed psychiatric evaluations and medication management for Anka's clients.

Testicular examination of D.L.

COMPLAINANT'S EVIDENCE

16. D.L. was admitted to Casa Phoenix on March 21, 2016, following his release from Telecare Heritage Psychiatric Facility (Telecare), where he had been hospitalized because he presented a danger to himself. Telecare records noted that he had no acute medical history. While D.L. was hospitalized at Telecare, he was given a complete physical examination. The examination records, dated March 15, 2016, include a notation that a genital exam was deferred at D.L.'s request. D.L. was 21 years old. He had a history of bipolar disorder, major depressive disorder, self-mutilation, a suicide attempt and a history of cannabis use. D.L.'s primary care physician at Kaiser was Dr. Leong.

17. On March 25, 2016, respondent conducted a psychiatric evaluation of D.L. Respondent's diagnoses included bipolar II disorder, cannabis use disorder, and rule out "cluster B personality disorder."

[3] Anka terminated respondent's employment following its investigation of the conduct that is the subject of this hearing.

18. On March 28, 2016, D.L. submitted a complaint to Anka pertaining to respondent. The complaint, submitted on a form provided by Anka, stated:

> I was asked insistently asking [*sic*] about my sexuality and I felt it was a little insistent, he also did a testicular check without gloves.
>
> Felt he was using his doctor's name to feel up patients bc also asked the other man to do the same thing.

19. D.L. made the following additional statements to Rick Kuchler, LMFT, Regional Director of Kaiser Programs:

> Dr. Durrani insisted to discuss my sexuality, asked me 5 times if I was gay after I told him I was straight. I told him that I had prostituted for money in the past. And he asked me if I had any sexual trauma. He told me that [Trazodone] can cause an erection that last[s] 5-6 hours, reduce the size of my testicles and increase my risk of testicular cancer. He asked to do a testicular exam. First he asked me to do a self-exam. I said I had a lump, that I always knew I had a lump.
>
> He then did his own exam on me, what bothered me was I was holding my penis while he was examining me and he told me to drop my penis. I thought that was weird. He didn't touch my penis.

20. On March 28, 2016, Dr. Harrison was informed that complaints were received about respondent. She opened an investigation and instructed respondent not to come to work until the investigation was complete. She performed what she described as a "painstaking" investigation, which included interviewing patients and staff at the three Anka facilities where respondent worked. Dr. Harrison was extremely concerned about patient safety; and at the same time, she respected respondent and realized that her findings could negatively impact his career.

21. On March 30, 2016, Dr. Harrison conducted a telephone interview with respondent regarding complaints made against him, including D.L.'s complaint. Dr. Harrison typed respondent's statements as he talked. Respondent admitted that he examined D.L.'s left testicle. The lump looked like a sebaceous cyst, and he told D.L. not to worry, and to follow up with his primary care physician. Respondent made a note to this effect in D.L.'s chart.

22. Respondent relayed to Dr. Harrison that D.L. told respondent that he "has been a male prostitute and he was sexually abused and he's worried about his testicle."

Respondent also told Dr. Harrison that D.L. said he had not seen his primary care doctor "for some time." Respondent also told Dr. Harrison that he explained the increased risk of testicular tumors in cannabis users to D.L., who had a history of cannabis use. Respondent then stated to Dr. Harrison:

> And [D.L.] said, he doesn't know how to check and can I help teach him how to check. I started to tell him and he said but I don't know how to do it. So I told him to drop his pants. But I'm not even gloved. So I told him, hold the left testicle with the left and the right testicle with the right hand. And he said look a cyst. So then I felt duty-bound that I should check. I said I don't have any gloves, so I pulled a tissue paper.

Dr. Harrison doubted respondent's explanation for his examination of D.L.'s left testicle because D.L. had not presented with a testicular complaint; D.L. stated that he "always knew" he had a lump; and, D.L. had a complete physical about 10 days earlier in which he requested that a genital exam be deferred. In her investigation report dated April 7, 2016, she determined that respondent had committed misconduct in connection with his treatment of D.L., and his services would be terminated immediately.[4]

23. In his interview with the Medical Board on December 8, 2016, respondent claimed that he did not tell D.L. to drop his pants, but that D.L. did so spontaneously. Respondent also claimed that he used a glove to examine D.L.[5] These claims were not documented in D.L.'s chart.

RESPONDENT'S EVIDENCE

24. Respondent took the job at Anka because it presented him with a challenging patient population. Many of his patients had developmental disabilities and substance abuse diagnoses in addition to psychiatric problems. Respondent claimed that he did not have direct access to patients' electronic medical records at Anka, and would ask staff to provide him with such access.

25. Respondent maintains that as the consulting psychiatrist, he was authorized to perform full physical exams on patients, and he did so, as needed. There was no other staff at Casa Phoenix qualified to do so. He claims that when he first started working for Anka, he was told to keep costs down and avoid sending patients for urgent or emergency care.

26. As to his treatment of D.L. respondent stated: the subject of testicular exams arose in the context of respondent telling D.L. of the correlation between testicular tumors in individuals with a history of cannabis use; D.L. said that he had not had a recent testicular

[4] Dr. Harrison also found that respondent committed misconduct in connection with his treatment of L.W. (Factual Finding 46.)

[5] He repeated these assertions at hearing

exam and did not know how to perform a self-exam; D.L. dropped his pants on his own and asked respondent to tell him how to examine his testicles; D.L. showed respondent a growth on the apex of his left testicle, and "appeared acutely worried." Respondent further claimed that in order to alleviate D.L.'s anxiety, he examined D.L.'s left testicle for two to three seconds and thought he felt a sebaceous cyst; and, that he "always wears a glove as a barrier" when he performs physical exams.

27. Respondent denied telling Dr. Harrison that he told D.L. to drop his pants. He also denies telling Dr. Harrison that he was ungloved when he performed the exam.

EXPERTS' OPINIONS AND ULTIMATE FINDINGS RE TESTICULAR EXAM ON D.L.

28. Dr. Harrison concluded that respondent's conduct of performing a genital examination of D.L.'s testicle was an egregious violation of psychiatrist-patient boundaries. Dr. Harrison opined that in settings outside of hospitals, such as Casa Phoenix, it is outside of the standard of care for a psychiatrist to perform a physical examination of a patient's genitals.[6] In settings such as Casa Phoenix, if a patient's genital complaint presents an immediate health risk and the psychiatrist is the only physician available to assess the acuity of the risk, a psychiatrist may perform a *visual* exam of a patient's genitals. According to Dr. Harrison, even a visual exam would have been inappropriate in this case because no emergency existed. In formulating her opinion she noted that acute testicular conditions are extremely painful. D.L. did not raise a complaint that he suffered from testicular pain; there was no evidence that his lump posed an acute health risk; and even if such a risk existed, a physical exam would still be inappropriate. D.L. had access to a variety of resources to address his concerns at Kaiser. In Dr. Harrison's view respondent should have referred D.L. to urgent care or his primary care physician in lieu of performing a physical examination of D.L.'s left testicle.

29. Dr. Chuang opined that the standard of care requires psychiatrists to maintain appropriate boundaries with their patients. Towards this end, it is standard practice for psychiatrists to avoid physical contact with their patients unless it pertains to monitoring side effects of psychiatric medications. There is no psychiatric indication for performing a testicular exam. Performing a genital exam on a patient is considered a boundary violation because it has the potential to cause psychiatric distress in the patient. In Dr. Chuang's words, such exams are "too fraught with sexual overtones to be considered an acceptable risk for a psychiatrist to take." This is especially true when treating patients such as D.L. who have a history of sexual trauma and prostitution. Dr. Chuang also emphasized that psychiatrists are not qualified to diagnose a patient's genital condition.

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[6] The experts used the terms testicle and genital interchangeably

If a psychiatrist believes that there is a need for a testicular exam, the standard of care is to refer the patient to a primary care provider, a specialist, urgent care, or emergency care, depending on the psychiatrist's assessment of the immediacy of the need for treatment. In Dr. Chuang's view, respondent's examination of D.L.'s left testicle with his thumb and forefinger, was medically unnecessary and was a "serious transgression" of the standard of care. Respondent should have referred D.L. to a medical provider rather than performing the exam himself. For these reasons, Dr. Chuang concluded that respondent committed an extreme departure from the standard of care when he performed a testicular exam on D.L. Even if respondent believed that he was authorized or required by his job duties to perform a genital exam on D.L., such authority or requirement, if it existed, does not abrogate his duty as a physician to act within the standard of care.

30. Dr. Rosenberg opined that respondent acted within the standard of care when he examined D.L.'s left testicle. Dr. Rosenberg based his conclusion on the following factors: the setting in which respondent delivered psychiatric care, respondent's background and experience, and D.L.'s clinical presentation. Dr. Rosenberg noted that, as the only physician at Casa Phoenix, it was within the standard of care for respondent to perform a preliminary assessment, or focused physical exams, to determine whether the medical issues presented by the patients required emergency or urgent treatment, or whether it could wait for a future visit with the patient's primary care physician.

In formulating his opinion regarding respondent's examination of D.L.'s left testicle, Dr. Rosenberg presumed that after respondent spoke to D.L. about the link between testicular cancer and marijuana use, D.L. exclaimed, in an agitated tone: "I have a lump"; and that D.L. spontaneously exposed his testicle to respondent, who observed a small growth there. Dr. Rosenberg also presumed that other options for medical care were not available to respondent. Additionally, Dr. Rosenberg noted that by virtue of his training and experience, respondent was well-qualified to perform such examinations. Dr. Rosenberg explained that "there is nothing inherently contrary to the standard of care for a psychiatrist to perform a physical exam on a patient, particularly a limited exam, to screen for problems to refer to a specialist." Under these circumstances, Dr. Rosenberg believed it was appropriate for respondent to perform a testicular exam in order to respond to D.L.'s distress and rule out a serious or acute testicular issue.

31. Dr. Bloch also opined that respondent's examination of D.L.'s left testicle was within the standard of care. In formulating his opinion he noted that respondent was treating D.L. in the context of a crisis residential treatment, and was not D.L.'s therapist; and respondent was the only licensed medical provider on staff. Dr. Bloch explained that, as a licensed physician, respondent was qualified to perform general physical examinations of patients, and his training in psychosomatic medicine gave him even more credibility to focus on physical exams. Respondent was tasked with performing an initial triage of new residents, which required him to assess patients' medical conditions to determine if there was a need for urgent or emergency care. Dr. Bloch opined that if respondent believed physical exams were medically necessary, it would be appropriate for him to perform them.

In Dr. Bloch's view, his understanding regarding the patients' limited resources to on-site medical care, and the setting in which they occurred led Dr. Bloch to conclude that respondent acted appropriately and within the standard of care when he examined D.L.'s left testicle. And, by examining D.L., Dr. Bloch maintained that respondent "was able to promptly and quickly address and resolve the patient's immediate concerns about a lump, and direct him to his primary care physician for further care as needed, after confirming the absence of an acute issue."

32. The opinions offered by Dr. Rosenberg and Dr. Bloch were not persuasive because their opinions are predicated on several assumptions that are factually incorrect. First, a variety of treatment modalities, including urgent and emergency care, were readily available to D.L. Second, respondent's examination of D.L.'s genitals was not in response to any immediate distress expressed by D.L. regarding the lump in his testicle. In fact, D.L. had received a full medical exam and declined a genital exam about 10 days before respondent examined him. As he wrote in his complaint regarding respondent, he has always had a lump. Third, according to respondent's statement[7] to Dr. Harrison, it appears that it was respondent who raised the issue of testicular exams; and the subject of D.L.'s testicular lump was not raised by D.L. until D.L.'s pants were down and respondent was talking to him about self-examination. Respondent's experts praise respondent for examining D.L.'s left testicle because his exam alleviated D.L.'s agitation and concerns about his lump when there were no other practical options for assessing him. The evidence, however, does not support their conclusions.

33. In contrast, the opinions by Dr. Harrison and Dr. Chuang that respondent committed a serious breach of care when he performed a testicular exam on a patient in a residential care facility, where there was no emergency and where there were ample medical resources available to address the patient's concerns, were persuasive. Dr. Harrison's testimony was the most persuasive because unlike the other experts, she was most familiar with the setting in which the conduct occurred, as well as the variety of medical resources available to D.L. It was therefore established that respondent's examination of D.L.'s left testicle was an extreme departure from the standard of care and grossly negligent.

Sufficiency of respondent's documentation in D.L.'s medical records

COMPLAINANT'S EVIDENCE

34. Complainant contends that respondent's chart notes in connection with his psychiatric evaluation of D.L. are inadequate and inaccurate. Respondent evaluated D.L., and recorded his impressions on a five-page form entitled psychological evaluation. Respondent completed the psychological evaluation form by hand, and his handwriting is difficult to read at times. Additionally, respondent did not complete the mental status exam

[7] This sequence of events is corroborated by D.L.'s written statements in which he states that he mentioned the lump after respondent asked to do a testicular exam.

checklist included in the psychiatric evaluation, although he did note that D.L. was positive for depression, anxiety and had what appeared like hypomanic episodes in the past. Complainant also alleges that respondent's charting was inadequate because he failed to document in his notes that D.L. had spontaneously dropped his pants; and, as respondent disclosed in his interview with the Medical Board, that he was "very uncomfortable" with D.L., because D.L. referred to respondent as "Bro" and "Dude," and made comments such as "nice car."[8]

RESPONDENT'S EVIDENCE

35. The focus of respondent's testimony was on his examination of D.L. It appeared from his testimony, however, that he believed his documentation in D.L.'s chart was adequate.

EXPERT OPINIONS AND ULTIMATE FINDINGS RE DOCUMENTATION ERRORS

36. Dr. Harrison opined that portions of respondent's documentation on the psychiatric evaluation were illegible, and in some instances they were also incomplete in that respondent did not document how D.L.'s pants "came down." While Dr. Harrison found respondent's documentation of D.L. deficient, she did not definitively state that respondent's chart entries for D.L. were outside of the standard of care.

37. Dr. Chuang noted that the standard of care requires that physicians maintain legible and accurate medical records. For psychiatrists, notes must include a patient's symptomatology, a mental status exam, a current treatment plan and rationale for making any treatment changes. The mental status exam is an important piece of a psychiatric evaluation in that it documents observable behavior, including speech, affect, mood, thought process and content, cognition, judgment and insight. Dr. Chuang found that respondent's documentation in connection with his psychiatric evaluation for D.L. was inadequate and insufficient and was a simple departure from the standard of care because portions of the notes are not legible; respondent did not complete the form documenting his mental status exam; and because respondent failed to document the circumstances surrounding his testicular exam of D.L.

Dr. Chuang also thought that if D.L. lowered his pants without being asked to do so, as respondent claimed in his interview with the Medical Board, it would have been important to document such behavior, which Dr. Chuang regarded as impulsive and provocative, and potentially relevant to respondent's diagnosis of bipolar disorder. Dr. Chuang also observed that he would not expect a psychiatrist to continue with a testicular examination after a patient spontaneously dropped his pants. Dr. Chuang also thought that respondent should have documented comments made by D.L. that made him very uncomfortable.

38. Dr. Rosenberg did not believe that respondent's chart notes were incomplete, but he agreed that portions of respondent's handwritten medical records for D.L. were difficult to

[8] Complainant also alleges that respondent's psychological evaluation did not contain a formal mental status examination. This allegation was not proved because at hearing, the page of D.L.'s record containing the formal mental status examination was provided by respondent.

read. Even if respondent's records were inadequate, Dr. Rosenberg opined that this transgression would only constitute a simple departure from the standard of care.

39. Dr. Bloch opined that while some entries in respondent's handwritten medical records for D.L. were difficult to read, and his notes were sometimes incomplete, respondent's record keeping was not outside of the standard of care applicable to what is expected of psychiatrists. Dr. Bloch thought that respondent's notes were sufficient to allow another psychiatrist to assume treatment of D.L.

40. The testimony of Dr. Bloch to the effect that respondent's handwritten notes were not so deficient as to constitute a failure to maintain adequate and accurate records and a departure from the standard of care was not persuasive. Instead, the persuasive testimony of Dr. Chuang, established that respondent's medical notes for D.L. were inadequate and inaccurate and constituted a simple departure from the standard of care.

Palpation of L.W.'s left inguinal lymph nodes

COMPLAINANT'S EVIDENCE

41. L.W. was 23 years old, had a history of schizophrenia and methamphetamine and cannabis use, and was homeless. L.W. came to Casa Phoenix following his discharge from the Kaiser Emergency Department. His mother had brought him to Kaiser for emergency treatment for a wound on his left toe.

42. On March 26, 2016, respondent performed a psychiatric evaluation of L.W. at Casa Phoenix. In L.W.'s records, under the section entitled focused physical exam, respondent notes: left big toe injury, already seen at the Emergency Department.

43. During his psychiatric evaluation, respondent palpated L.W.'s left inguinal lymph nodes[9] over L.W.'s clothing. Respondent made a note in the past medical history: no lymph node enlargement. During his telephone interview with Dr. Harrison several days after the incident, respondent stated that he palpated L.W.'s left inguinal nodes because L.W.'s toe looked "red and very bad," and he wanted to assess whether the toe was infected and required urgent care.

RESPONDENT'S EVIDENCE

44. When respondent met L.W., he noticed that L.W. was barefooted, he walked with a limp, his feet were dirty, and he had a bloody bandage on his left toe. Respondent testified that L.W. "appeared flushed," but did not note this in L.W.'s chart. Respondent did not see the

[9] Inguinal lymph nodes are located in the groin.

presence of red striations on L.W.'s lower left limb. Respondent performed an inguinal node inspection over L.W.'s clothes to assess whether L.W.'s toe might be infected and rule out sepsis.

EXPERTS' OPINIONS AND ULTIMATE FINDINGS RE PALPATION OF LEFT INGUINAL AREA

45. Dr. Harrison opined that respondent's examination of L.W.'s inguinal lymph nodes was an egregious violation of the standard of practice. If respondent was concerned that L.W.'s toe injury was infected and presented a risk of sepsis, he should have sent L.W. to urgent care or back to the emergency room for treatment. As a Kaiser patient, these resources were readily available to L.W. Respondent's examination of L.W.'s inguinal nodes was not only outside of the standard of care, it was also medically unnecessary because if L.W.'s inguinal nodes were enlarged as a result of a toe infection there would be visible signs of the infection on L.W.'s toe and leg. Respondent's inguinal exam was also ineffective because one cannot perform an inguinal exam over a patient's clothing; the physician has to palpate the bare node to determine if it is enlarged.

46. Dr. Chuang opined that there is no psychiatric indication for performing an inguinal lymph node exam on a patient; it is a boundary violation and it has the potential to provoke psychological distress on the part of the patient. If respondent believed there was an emergency, and possibly sepsis, respondent should have sent L.W. to the emergency room to allow him to be examined by a physician who is qualified to make that assessment. Dr. Chuang concluded that respondent committed an extreme departure from the standard of care when he performed an inguinal lymph node exam on L.W. Even if respondent believed that he was authorized or required by his job duties to perform an inguinal lymph node exam, such authority or requirement does not abrogate respondent's duty, as a psychiatrist, to act within the standard of care.

47. Dr. Rosenberg opined that respondent's examination of L.W.'s left inguinal nodes was appropriate and necessary, given L.W.'s clinical presentation. Dr. Rosenberg maintained that respondent's exam was appropriate because he was looking for signs of a spreading wound infection, such as heat, red streaks appearing from wound, and swelling; he acknowledged, however, that respondent's chart notes do not document the presence of these symptoms. Given the risk of infection, Dr. Rosenberg describes respondent's examination that was conducted to rule out a serious infection, as within the standard of care and "commendable."

48. Dr. Bloch found that respondent's examination of L.W.'s left inguinal nodes was appropriate and within the standard of care because respondent was the only physician at the facility and was responsible for triaging patients. Additionally, respondent was not conducting therapy with L.W. Dr. Bloch described respondent's examination of L.W. as so thorough, that "in a way it was commendable." In formulating his opinion, he noted that the exam was "both brief and adequate to resolve the patient's acute anxiety about a potentially serious medical problem." Dr. Bloch also postulated that "Dr. Harrison had it in for [respondent]." At the same time, Dr. Bloch acknowledged that there were no notes in L.W.'s records documenting the

existence of swelling, redness, heat, and/or red streaks emanating from the sight of the wound, or that he suffered from an altered mental state, or low blood pressure or respiratory rate, which are all signs of a serious infection.

49. The opinions of Dr. Bloch and Dr. Rosenberg regarding the necessity of respondent's exam are not persuasive. They presume an urgent clinical presentation on the part of L.W. and the absence of available medical care available to L.W. Neither presumption is correct. Additionally, Dr. Bloch's assumption that L.W. experienced "acute anxiety" about the possibility of sepsis is not supported by the record. L.W. had just received emergency care for his toe and had been treated and released. Additionally, in respondent's interview with Dr. Harrison, he did not maintain that he performed the exam to quell L.W.'s acute anxiety about his toe; rather, he maintained he decided to perform the inguinal exam because L.W.'s toe looked "red and very bad," and he wanted to be sure that the infection had not spread.

50. The opinions by Dr. Harrison and Dr. Chuang that respondent committed a serious breach of care when he performed an exam on L.W.'s left inguinal node were persuasive. As these experts noted, the exam constituted a boundary violation; it was medically unnecessary, given that L.W.'s toe had just been treated in the emergency room; there was an absence of other clinical indications of a systemic infection; and urgent and emergency treatment was readily available to L.W. It was therefore established that respondent's examination of L.W.'s left inguinal nodes was an extreme departure from the standard of care and grossly negligent.

Sufficiency of respondent's documentation in L.W.'s medical records

COMPLAINANT'S EVIDENCE

51. Complainant contends that respondent's chart notes in connection with his psychiatric evaluation of L.W. are inadequate and inaccurate because respondent's handwriting is barely legible in a number of places. In other places, described below, his documentation is incomplete. Respondent did not clearly document his examination of L.W.'s inguinal nodes in the medical records. A note in the past medical history section of respondent's psychiatric evaluation states "no lymph node enlargement," but it does not identify which node was examined. Respondent did not complete the mental status exam checklist included in the psychiatric evaluation, but he did make a few handwritten notes that L.W. 'worried a lot," was "very unkempt, [had] very poor impulses, and was not suicidal or homicidal." Respondent also did not document the symptoms associated with schizophrenia, such as the presence of a disordered thought process and/or psychotic symptoms such as hallucinations or delusions.

RESPONDENT'S EVIDENCE

52. The focus of respondent's testimony was on his examination of L.W. It appeared from his testimony, however, that he believed his documentation in L.W.'s chart was adequate.

EXPERT OPINIONS AND ULTIMATE FINDINGS RE DOCUMENTATION ERRORS

53. Dr. Harrison opined that respondent's notations in the psychiatric evaluation of L.W. were incomplete and below the standard of care because the notes did not provide sufficient information to allow another psychiatrist who might take over treatment of L.W. to formulate a treatment plan.

54. Dr. Chuang opined that respondent's documentation in connection with his psychiatric evaluation of L.W. was inadequate and inaccurate because portions of it were illegible, and respondent did not complete the form documenting his mental status exam. Additionally, respondent's documentation of L.W.'s mental status examination does not contain information relevant to L.W.'s diagnosis of schizophrenia, such as abnormalities in L.W.'s thought process or psychotic symptoms, hallucinations, or delusions. Respondent's notes do not identify which inguinal node was examined. In Dr. Chuang's view, this lack of documentation constitutes a simple departure from the standard of care.

55. Dr. Rosenberg opined that respondent's medical records for L.W. were difficult to read. To the extent that respondent's notes are inadequate, this transgression would only constitute a simple departure from the standard of care.

56. Dr. Bloch opined that while portions of respondent's notations were difficult to read and sometimes incomplete, respondent's record keeping was not outside of the standard of care applicable to what is expected of psychiatrists. Dr. Bloch thought that respondent's notes were sufficient to allow another psychiatrist to assume treatment of L.W.

57. The testimony of Dr. Bloch to the effect that respondent's handwritten notes were not so deficient as to constitute a failure to maintain adequate and accurate records and a departure from the standard of care was not persuasive. Instead, the persuasive testimony of the Medical Board's experts, established that respondent's medical notes for L.W. were inadequate and inaccurate and constituted a simple departure from the standard of care.

Credibility Findings

58. Respondent's testimony at hearing and to the Medical Board lacked credibility and candor on several key points. For example, respondent testified and told the Medical Board, that D.L. dropped his pants spontaneously, and that he examined D.L.'s left testicle with a glove. This testimony contradicts respondent's statements to Dr. Harrison that he told to lower his pants, and that he performed the examination with a tissue and not a glove. Respondent's statements to Dr. Harrison are found to be credible because they were made several days after the incident and because they are also consistent with D.L.'s written statements. Respondent also testified that he performed the testicular exam on D.L. in response to D.L.'s complaint about a cyst on his left testicle. This statement does not align with respondent's statement to Dr. Harrison that D.L. mentioned the lump after D.L. had lowered his pants and was performing a self-exam. It is also hard to believe that D.L. expressed agitation about his testicular lump when there is no such documentation in the

medical records, and because D.L. had deferred a genital exam when he had a physical examination just 10 days earlier.

LEGAL CONCLUSIONS

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. A licensee may be subject to discipline for violating the Medical Practice Act (Bus. & Prof. Code, § 2234, subd. (a)), or for committing gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)),[10] or for failing to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

Cause for discipline

2. By reason of the matters set forth in Factual Findings 33 and 50, the evidence established that respondent was grossly negligent when he performed a testicular examination of D.L., and an examination of L.W.'s inguinal nodes. Additionally, by reason of the matters set forth in Factual Findings 40 and 57, respondent failed to maintain adequate and accurate medical records for D.L. and L.W.; and because his record-keeping for these two patients fell below the standard of care, these errors also constituted repeated acts of negligence. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivisions (b) and (c), and Business and Professions Code section 2266, in conjunction with Business and Professions Code section 2234, subdivision (a).

Disciplinary determination

3. As cause for discipline has been established, the appropriate level of discipline must be determined. The Medical Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) (12th ed., 2016) recommend, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's unprofessional conduct. The maximum discipline is revocation. Complainant argues that revocation of respondent's Certificate is necessary to protect the public. Respondent contends that he did nothing wrong, and should instead be commended for his treatment of underserved populations.[11]

In determining whether a licensee is sufficiently rehabilitated to justify continued licensure, it must be kept in mind that, in exercising its licensing functions, protection of the public is the highest priority of the Medical Board. The Medical Board seeks to ensure that licensees will, among other things, be completely candid and worthy of the responsibilities

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[10] Under the language of the statute, in order to be repeated there must be two or more separate and distinct negligent acts. (Bus. & Prof. Code, § 2234, subd. (c).)

[11] Respondent alluded to being willing to take a medical record keeping course.

they bear by reason of their licensure. However, according to Business and Professions Code section 2229, the Board must also "take action that is calculated to aid in the rehabilitation of the licensee." In order to determine the level of discipline to be imposed, the board has criteria set forth in regulation that is to be considered: (a) the nature and severity of the act or offense; (b) the total criminal record; (c) the time that has elapsed since commission of the act or offense; (d) whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against such person; (e) if applicable, evidence of expungement proceedings; and (f) if applicable, evidence of rehabilitation submitted by the licensee. (16 C.C.R. §1360.1).

Here, respondent engaged in a testicular examination of Patient D.L. and palpation of Patient L.W.'s left inguinal lymph nodes over his clothing. Both examinations, while within licensee's scope of practice, were determined by complainant's experts to be a serious breach of care. Both patients had other resources available to address any of their physical conditions or complaints, and as such, respondent should have referred any physical examination of these patients since the record showed no evidence of any emergency or life-threatening conditions that would have necessitated a physical examination at this residential treatment facility, which was not equipped to provide physical examinations to patients. Also, the evidence showed that respondent was deficient in his record keeping since he failed to make note of what occurred and what was said during these physical examinations.

It has been over 2.5 years since these acts took place and since then, no complaints or other actions have been filed against respondent. The two examinations of patients did not lead to any criminal charges or convictions against respondent, and there is no past or pending criminal history against respondent. Respondent has practiced psychiatry for many years and has not been previously disciplined by the Board. Any compliance with criminal probation or other sanctions, as well as evidence of expungement proceedings are inapplicable. Other than respondent's testimony at the administrative hearing and the evidence presented at oral argument, there was no written evidence of rehabilitation that was submitted by respondent.

Based on a totality of the above-mentioned criteria and related facts and circumstances, the public would be adequately protected by placing Respondent on five (5) years' probation with appropriate terms and conditions; specifically, terms to address his record keeping and boundary issues with patients, as well as having a practice monitor and a third party chaperone when conducting any type of physical examination of his patients. These additional terms and conditions of probation will ensure that any physical examination that respondent performs is appropriate given the applicable patient setting as well as the circumstances surrounding a patient's physical condition.

ORDER

Certificate No. A 728025 issued to respondent Khurram Khan Durrani, M.D. is revoked. However, the revocation is stayed and respondent is placed on probation for five (5) years upon the following terms and conditions

1. Medical Record Keeping Course

Within sixty (60) calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

2. Professional Boundaries Program

Within sixty (60) calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24-hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six (6) months after respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures

necessary to ensure that respondent can practice safely. Respondent shall comply with program recommendations. At the completion of the program, respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The program has the authority to determine whether or not respondent successfully completed the program.

A professional boundaries course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

3. Monitoring - Practice

Within thirty (30) calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within fifteen (15) calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within sixty (60) calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice monitor shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at al times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within sixty (60) calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee, which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standard of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within ten (10) calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility with fifteen (15) calendar days. If respondent fails to obtain approval of a replacement monitor within sixty (60) calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

4. Third Party Chaperone

During probation, respondent shall have a third party chaperone present while conducting any physical examination of any patient. Respondent shall, within thirty (30) calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

If respondent fails to obtain approval of a third party chaperone within sixty (60) calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.

Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision and Accusation, and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The shall contain the following: (1) patient initials, address, and telephone number; (2) medical record number; and (3) date of service(s). Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and

shall retain the log for the entire term of probation. Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee.

If the third party chaperone resigns or is no longer available, respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within thirty (30) calendar days of the resignation or unavailability of the third party chaperone, respondent shall receive a notification from the Board of its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement third party chaperone is approved and assumes monitoring responsibility.

5. Notification

Within seven (7) days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change in hospitals, other facilities, or insurance carrier.

6. Supervision of Physician Assistants and Advanced Practice Nurses.

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. Obey All Laws.

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. Quarterly Declarations.

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than ten (10) calendar days after the end of the preceding quarter.

9. General Probation Requirements.

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the dates of departure and return.

10. Interview with the Board or its Designee.

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. Non-practice While on Probation.

Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than thirty (30) calendar days and within fifteen (15) calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least forty (40) hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non- practice.

In the event respondent's period of non-practice while on probation exceeds eighteen (18) calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

12. Completion of Probation.

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

13. Violation of Probation.

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. License Surrender.

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. Probation Monitoring Costs.

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

This Decision shall become effective at 5:00 pm on December 7, 2018.

IT IS SO ORDERED November 9, 2018.

RONALD H. LEWIS, M.D., CHAIR
PANEL A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
KHURRAM KHAN DURRANI, M.D.	)	
	)	Case No.: 8002016021897
Physician's & Surgeon's	)	
Certificate No: A72805	)	OAH No.: 2018010095
	)	
Respondent	)	
	)	
	)	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the level of discipline ordered is sufficient to protect the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Diamond Court Reporters, 1107 2nd Street, Ste. 300, Sacramento, CA 95814. The telephone number is (916) 498-9288

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties' attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-6668
Attention: Michelle Solario

Date: July 31, 2018

Ronald H. Lewis, M.D.
Chair, Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of:	Case No. 800-2016-021897
KHURRUM KHAN DURRANI, M.D.	OAH No. 2018010095
Physician's and Surgeon's Certificate No. A 72805,	**ORDER GRANTING REQUEST TO CORRECT THE PROPOSED DECISION**
Respondent.	

On June 21, 2018, Administrative Law Judge Diane Schneider of the Office of Administrative Hearings issued a proposed decision in this matter. On June 29, 2018, the Medical Board filed an application to correct the proposed decision. Respondent does not oppose the application.

Finding 42, refers to footnote 9, but there is no footnote 9. This reference to footnote 9 should be deleted, and the following footnotes renumbered. Correction of these errors is authorized by law. (Cal. Code Regs., tit. 1, § 1048.)

Good cause appearing:

1. Complainant's motion to correct the Proposed Decision is granted. The Proposed Decision is corrected as set forth above.

2. A Corrected Proposed Decision incorporating these changes is attached to this order.

3. This order and the agency's application are hereby made a part of the record in this case.

DATE: July 16, 2018

DocuSigned by:
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DAVID BENJAMIN
Presiding Administrative Law Judge
Office of Administrative Hearings

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KHURRAM KHAN DURRANI, M.D. Physician's and Surgeon's Certificate No. A 72805, Respondent.	Case No. 800-2016-021897 OAH No. 2018010095

CORRECTED PROPOSED DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on May 21 and 22, 2018, in Oakland, California.

Greg W. Chambers, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Kevin Mintz, Attorney at Law, Rankin, Sproat, Mires, Reynolds, Shuey & Mintz, represented respondent Khurram Khan Durrani, M.D., who was present.

The record closed and the matter was submitted for decision on May 22, 2018.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer issued the Accusation in her official capacity as Executive Director of the Medical Board of California, Department of Consumer Affairs (Medical Board).

2. On August 10, 2000, the Medical Board issued Physician's and Surgeon's Certificate (Certificate) No. A 72805 to Khurram Khan Durrani, M.D. (respondent). Respondent's Certificate was in full force and effect at the times of the acts set forth below and will expire on April 30, 2020, unless renewed.

3. The Accusation alleges that respondent committed unprofessional conduct (repeated acts of negligence and gross negligence, and failure to maintain adequate and accurate

medical records) in his treatment of patients D.L. and L.W.[1] Respondent filed a notice of defense and this hearing followed.

4. The standard of proof applied in making the factual findings is clear and convincing evidence to a reasonable certainty.

Expert testimony at hearing

5. The experts who testified at hearing were familiar with the standard of care and laws applicable to the professional conduct of psychiatrists in California. Each expert reviewed pertinent medical records and documents, as well as the transcript from the Medical Board's interview with respondent on December 8, 2016. They each offered an opinion as to whether respondent committed unprofessional conduct in connection with his treatment of D.L. and L.W.

MEDICAL BOARD'S EXPERTS

6. Nzinga Ajabu Harrison, M.D., graduated from the University of Pennsylvania Medical School and completed her internship and residency in psychiatry at Emory University. She received her license to practice medicine in Georgia in 2004. She is Board-certified in adult psychiatry and holds positions at Morehouse School of Medicine (Adjunct Clinical Assistant Professor) and DeBusk College of Osteopathic Medicine (Clinical Adjunct Faculty). Dr. Harrison is also licensed to practice medicine in California. She has worked for Anka Behavioral Health (Anka) for almost five years; her current position is Chief Medical Officer (CMO). Dr. Harrison also has a small private practice.

7. Kenneth S. Chuang, M.D., graduated from Harvard Medical School in 1995. He completed a residency in 1999, and a fellowship in 2000, at the Neuropsychiatric Institute at the University of California, Los Angeles (UCLA). Dr. Chuang is Board-certified in adult psychiatry. Dr. Chuang is an Associate Clinical Professor at UCLA's Medical School, and an attending psychiatrist at the Edelman Mental Health Clinic, Los Angeles County Department of Mental Health. Dr. Chuang is also a medical reviewer for the Medical Board.

RESPONDENT'S EXPERTS

8. John George Rosenberg, M.D., M.P.H., graduated from the University of California, San Francisco, Medical School in 1982, after having received a master's degree in public health from University of California, Berkeley, School of Public Health. Dr. Rosenberg completed his residency in 1986, at the University of California, San Francisco, Langley Porter Institute. He has practiced psychiatry for about 31 years. He has held positions including Medical Director of various units at Alta Bates Medical Center, and President of the Alta Bates Medical Staff. Dr. Rosenberg is currently a Staff Psychiatrist at

[1] The patients are referred to by initials to protect their privacy.

the Berkeley Therapy Institute, where he specializes in performing work related to physician impairment.

9. Mark Randall Bloch, M.D., graduated from Dartmouth Medical School and completed his residency at Stanford University Hospital. Dr. Bloch is Board-certified in adult psychiatry. Dr. Bloch is currently in private practice. He also works as a Staff Physician and a clinical faculty member at Stanford University Hospital, and as the Associate Medical Director at the Affiliated Research Institute in Berkeley.

Respondent's background

10. Respondent received his medical degree from Khyber Medical College in Pakistan. He completed a series of four internships, which each lasted six months, in general surgery, internal medicine, dermatology and psychiatry. Additionally, he completed a six-month internship at Edgware General Hospital in London; a six-month externship in psychiatry at Washington Hospital Center, in Washington, D.C.; and, residency and fellowships training at St. Elizabeth's Hospital, Washington, D.C., George Washington University Hospital, Stanford University, and University of California, Los Angeles. Respondent is Board-certified in child and adolescent psychiatry, adult psychiatry, and psychosomatic medicine.

11. Since 2003, respondent has practiced outpatient community psychiatry at the Behavioral Health Services for the County of San Joaquin. He began as a staff psychiatrist, and for the past four years he has held the position of Medical Director. As Medical Director, he supervises 30 physicians. Between 2006 and 2016, respondent was employed by Anka as an independent contractor/consulting physician, where he worked about five hours per week. This is respondent's first disciplinary matter before the Medical Board.

Setting in which alleged misconduct occurred

12. At the time of the alleged misconduct, D.L. and L.W. were patients at Casa Phoenix, an adult mental health crisis residential treatment program that is operated by Anka.[2] Casa Phoenix is located in a residential home and houses six patients. As Dr. Harrison explained, Casa Phoenix is a "step down from inpatient psychiatric care," and "stands in between inpatient and outpatient" treatment settings.

13. Psychiatric evaluations are conducted in either the downstairs group room or the upstairs administrative office of Casa Phoenix. Because psychiatrists are not expected to routinely perform physical exams, there are no exam rooms or exam supplies, such as gloves and body coverings. Psychiatrists performing psychiatric evaluations are also expected to triage patients, meaning that they assess patients' medical issues and determine the degree of

[2] Anka operates a number of residential treatment programs that serve mentally ill and developmentally disabled clients.

medical intervention that is required. Dr. Harrison explained that any physical exams performed as part of the triage process must conform to the standard of care.

14. At the time of the incidents, all Anka patients were Kaiser Permanente (Kaiser) patients and had access to Kaiser medical services. Anka staff was instructed to use Kaiser services, such as the advice nurse, urgent care, emergency care, or a referral to a primary care physician, to address patients' physical health concerns.

15. At the time of the alleged misconduct, respondent was a part-time consulting psychiatrist[3] in several of Anka's facilities, including Casa Phoenix, where he performed psychiatric evaluations and medication management for Anka's clients.

Testicular examination of D.L.

COMPLAINANT'S EVIDENCE

16. D.L. was admitted to Casa Phoenix on March 21, 2016, following his release from Telecare Heritage Psychiatric Facility (Telecare), where he had been hospitalized because he presented a danger to himself. Telecare records noted that he had no acute medical history. While D.L. was hospitalized at Telecare, he was given a complete physical examination. The examination records, dated March 15, 2016, include a notation that a genital exam was deferred at D.L.'s request. D.L. was 21 years old. He had a history of bipolar disorder, major depressive disorder, self-mutilation, a suicide attempt and a history of cannabis use. D.L.'s primary care physician at Kaiser was Dr. Leong.

17. On March 25, 2016, respondent conducted a psychiatric evaluation of D.L. Respondent's diagnoses included bipolar II disorder, cannabis use disorder, and rule out "cluster B personality disorder."

18. On March 28, 2016, D.L. submitted a complaint to Anka pertaining to respondent. The complaint, submitted on a form provided by Anka, stated:

> I was asked insistently asking [*sic*] about my sexuality and I felt it was a little insistent, he also did a testicular check without gloves.
>
> Felt he was using his doctor's name to feel up patients bc also asked the other man to do the same thing.

19. D.L. made the following additional statements to Rick Kuchler, LMFT, Regional Director of Kaiser Programs:

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[3] Anka terminated respondent's conduct following its investigation of the conduct that is the subject of this hearing.

> Dr. Durrani insisted to discuss my sexuality, asked me 5 times if I was gay after I told him I was straight. I told him that I had prostituted for money in the past. And he asked me if I had any sexual trauma. He told me that [Trazodone] can cause an erection that last[s] 5-6 hours, reduce the size of my testicles and increase my risk of testicular cancer. He asked to do a testicular exam. First he asked me to do a self-exam. I said I had a lump, that I always knew I had a lump.
>
> He then did his own exam on me, what bothered me was I was holding my penis while he was examining me and he told me to drop my penis. I thought that was weird. He didn't touch my penis.

20. On March 28, 2016, Dr. Harrison was informed that complaints were received about respondent. She opened an investigation and instructed respondent not to come to work until the investigation was complete. She performed what she described as a "painstaking" investigation, which included interviewing patients and staff at the three Anka facilities where respondent worked. Dr. Harrison was extremely concerned about patient safety; and at the same time, she respected respondent and realized that her findings could negatively impact his career.

21. On March 30, 2016, Dr. Harrison conducted a telephone interview with respondent regarding complaints made against him, including D.L.'s complaint. Dr. Harrison typed respondent's statements as he talked. Respondent admitted that he examined D.L.'s left testicle. The lump looked like a sebaceous cyst, and he told D.L. not to worry, and to follow up with his primary care physician. Respondent made a note to this effect in D.L.'s chart.

22. Respondent relayed to Dr. Harrison that D.L. told respondent that he "has been a male prostitute and he was sexually abused and he's worried about his testicle." Respondent also told Dr. Harrison that D.L. said he had not seen his primary care doctor "for some time." Respondent also told Dr. Harrison that he explained the increased risk of testicular tumors in cannabis users to D.L., who had a history of cannabis use. Respondent then stated to Dr. Harrison:

> And [D.L.] said, he doesn't know how to check and can I help teach him how to check. I started to tell him and he said but I don't know how to do it. So I told him to drop his pants. But I'm not even gloved. So I told him, hold the left testicle with the left and the right testicle with the right hand. And he said look a cyst. So then I felt duty-bound that I should check. I said I don't have any gloves, so I pulled a tissue paper.

Dr. Harrison doubted respondent's explanation for his examination of D.L.'s left testicle because D.L. had not presented with a testicular complaint; D.L. stated that he "always knew" he had a lump; and, D.L. had a complete physical about 10 days earlier in which he requested that a genital exam be deferred. In her investigation report dated April 7, 2016, she determined that respondent had committed misconduct in connection with his treatment of D.L., and his services would be terminated immediately.[4]

23. In his interview with the Medical Board on December 8, 2016, respondent claimed that he did not tell D.L. to drop his pants, but that D.L. did so spontaneously. Respondent also claimed that he used a glove to examine D.L.[5] These claims were not documented in D.L.'s chart.

RESPONDENT'S EVIDENCE

24. Respondent took the job at Anka because it presented him with a challenging patient population. Many of his patients had developmental disabilities and substance abuse diagnoses in addition to psychiatric problems. Respondent claimed that he did not have direct access to patients' electronic medical records at Anka, and would ask staff to provide him with such access.

25. Respondent maintains that as the consulting psychiatrist, he was authorized to perform full physical exams on patients, and he did so, as needed. There was no other staff at Casa Phoenix qualified to do so. He claims that when he first started working for Anka, he was told to keep costs down and avoid sending patients for urgent or emergency care.

26. As to his treatment of D.L. respondent stated: the subject of testicular exams arose in the context of respondent telling D.L. of the correlation between testicular tumors in individuals with a history of cannabis use; D.L. said that he had not had a recent testicular exam and did not know how to perform a self-exam; D.L. dropped his pants on his own and asked respondent to tell him how to examine his testicles; D.L. showed respondent a growth on the apex of his left testicle, and "appeared acutely worried." Respondent further claimed that in order to alleviate D.L.'s anxiety, he examined D.L.'s left testicle for two to three seconds and thought he felt a sebaceous cyst; and, that he "always wears a glove as a barrier" when he performs physical exams.

27. Respondent denied telling Dr. Harrison that he told D.L. to drop his pants. He also denies telling Dr. Harrison that he was ungloved when he performed the exam.

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[4] Dr. Harrison also found that respondent committed misconduct in connection with his treatment of L.W. (Factual Finding 46.)

[5] He repeated these assertions at hearing.

EXPERTS' OPINIONS AND ULTIMATE FINDINGS RE TESTICULAR EXAM ON D.L.

28. Dr. Harrison concluded that respondent's conduct of performing a genital examination of D.L.'s testicle was an egregious violation of psychiatrist-patient boundaries. Dr. Harrison opined that in settings outside of hospitals, such as Casa Phoenix, it is outside of the standard of care for a psychiatrist to perform a physical examination of a patient's genitals.[6] In settings such as Casa Phoenix, if a patient's genital complaint presents an immediate health risk and the psychiatrist is the only physician available to assess the acuity of the risk, a psychiatrist may perform a *visual* exam of a patient's genitals. According to Dr. Harrison, even a visual exam would have been inappropriate in this case because no emergency existed. In formulating her opinion she noted that acute testicular conditions are extremely painful. D.L. did not raise a complaint that he suffered from testicular pain; there was no evidence that his lump posed an acute health risk; and even if such a risk existed, a physical exam would still be inappropriate. D.L. had access to a variety of resources to address his concerns at Kaiser. In Dr. Harrison's view respondent should have referred D.L. to urgent care or his primary care physician in lieu of performing a physical examination of D.L.'s left testicle.

29. Dr. Chuang opined that the standard of care requires psychiatrists to maintain appropriate boundaries with their patients. Towards this end, it is standard practice for psychiatrists to avoid physical contact with their patients unless it pertains to monitoring side effects of psychiatric medications. There is no psychiatric indication for performing a testicular exam. Performing a genital exam on a patient is considered a boundary violation because it has the potential to cause psychiatric distress in the patient. In Dr. Chuang's words, such exams are "too fraught with sexual overtones to be considered an acceptable risk for a psychiatrist to take." This is especially true when treating patients such as D.L. who have a history of sexual trauma and prostitution. Dr. Chuang also emphasized that psychiatrists are not qualified to diagnose a patient's genital condition.

If a psychiatrist believes that there is a need for a testicular exam, the standard of care is to refer the patient to a primary care provider, a specialist, urgent care, or emergency care, depending on the psychiatrist's assessment of the immediacy of the need for treatment. In Dr. Chuang's view, respondent's examination of D.L.'s left testicle with his thumb and forefinger, was medically unnecessary and was a "serious transgression" of the standard of care. Respondent should have referred D.L. to a medical provider rather than performing the exam himself. For these reasons, Dr. Chuang concluded that respondent committed an extreme departure from the standard of care when he performed a testicular exam on D.L. Even if respondent believed that he was authorized or required by his job duties to perform a genital exam on D.L., such authority or requirement, if it existed, does not abrogate his duty as a physician to act within the standard of care.

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[6] The experts used the terms testicle and genital interchangeably.

30. Dr. Rosenberg opined that respondent acted within the standard of care when he examined D.L.'s left testicle. Dr. Rosenberg based his conclusion on the following factors: the setting in which respondent delivered psychiatric care, respondent's background and experience, and D.L.'s clinical presentation. Dr. Rosenberg noted that, as the only physician at Casa Phoenix, it was within the standard of care for respondent to perform a preliminary assessment, or focused physical exams, to determine whether the medical issues presented by the patients required emergency or urgent treatment, or whether it could wait for a future visit with the patient's primary care physician.

In formulating his opinion regarding respondent's examination of D.L.'s left testicle, Dr. Rosenberg presumed that after respondent spoke to D.L. about the link between testicular cancer and marijuana use, D.L. exclaimed, in an agitated tone: "I have a lump"; and that D.L. spontaneously exposed his testicle to respondent, who observed a small growth there. Dr. Rosenberg also presumed that other options for medical care were not available to respondent. Additionally, Dr. Rosenberg noted that by virtue of his training and experience, respondent was well-qualified to perform such examinations. Dr. Rosenberg explained that "there is nothing inherently contrary to the standard of care for a psychiatrist to perform a physical exam on a patient, particularly a limited exam, to screen for problems to refer to a specialist." Under these circumstances, Dr. Rosenberg believed it was appropriate for respondent to perform a testicular exam in order to respond to D.L.'s distress and rule out a serious or acute testicular issue.

31. Dr. Bloch also opined that respondent's examination of D.L.'s left testicle was within the standard of care. In formulating his opinion he noted that respondent was treating D.L. in the context of a crisis residential treatment, and was not D.L.'s therapist; and respondent was the only licensed medical provider on staff. Dr. Bloch explained that, as a licensed physician, respondent was qualified to perform general physical examinations of patients, and his training in psychosomatic medicine gave him even more credibility to focus on physical exams. Respondent was tasked with performing an initial triage of new residents, which required him to assess patients' medical conditions to determine if there was a need for urgent or emergency care. Dr. Bloch opined that if respondent believed physical exams were medically necessary, it would be appropriate for him to perform them.

In Dr. Bloch's view, his understanding regarding the patients' limited resources to on-site medical care, and the setting in which they occurred led Dr. Bloch to conclude that respondent acted appropriately and within the standard of care when he examined D.L.'s left testicle. And, by examining D.L., Dr. Bloch maintained that respondent "was able to promptly and quickly address and resolve the patient's immediate concerns about a lump, and direct him to his primary care physician for further care as needed, after confirming the absence of an acute issue."

32. The opinions offered by Dr. Rosenberg and Dr. Bloch were not persuasive because their opinions are predicated on several assumptions that are factually incorrect. First, a variety of treatment modalities, including urgent and emergency care, were readily available to D.L. Second, respondent's examination of D.L.'s genitals was not in response to any

immediate distress expressed by D.L. regarding the lump in his testicle. In fact, D.L. had received a full medical exam and declined a genital exam about 10 days before respondent examined him. As he wrote in his complaint regarding respondent, he has always had a lump. Third, according to respondent's statement[7] to Dr. Harrison, it appears that it was respondent who raised the issue of testicular exams; and the subject of D.L.'s testicular lump was not raised by D.L. until D.L.'s pants were down and respondent was talking to him about self-examination. Respondent's experts praise respondent for examining D.L.'s left testicle because his exam alleviated D.L.'s agitation and concerns about his lump when there were no other practical options for assessing him. The evidence, however, does not support their conclusions.

33. In contrast, the opinions by Dr. Harrison and Dr. Chuang that respondent committed a serious breach of care when he performed a testicular exam on a patient in a residential care facility, where there was no emergency and where there were ample medical resources available to address the patient's concerns, were persuasive. Dr. Harrison's testimony was the most persuasive because unlike the other experts, she was most familiar with the setting in which the conduct occurred, as well as the variety of medical resources available to D.L. It was therefore established that respondent's examination of D.L.'s left testicle was an extreme departure from the standard of care and grossly negligent.

Sufficiency of respondent's documentation in D.L.'s medical records

COMPLAINANT'S EVIDENCE

34. Complainant contends that respondent's chart notes in connection with his psychiatric evaluation of D.L. are inadequate and inaccurate. Respondent evaluated D.L., and recorded his impressions on a five-page form entitled psychological evaluation. Respondent completed the psychological evaluation form by hand, and his handwriting is difficult to read at times. Additionally, respondent did not complete the mental status exam checklist included in the psychiatric evaluation, although he did note that D.L. was positive for depression, anxiety and had what appeared like hypomanic episodes in the past. Complainant also alleges that respondent's charting was inadequate because he failed to document in his notes that D.L. had spontaneously dropped his pants; and, as respondent disclosed in his interview with the Medical Board, that he was "very uncomfortable" with D.L., because D.L. referred to respondent as "Bro" and "Dude," and made comments such as "nice car."[8]

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[7] This sequence of events is corroborated by D.L.'s written statements in which he states that he mentioned the lump after respondent asked to do a testicular exam.

[8] Complainant also alleges that respondent's psychological evaluation did not contain a formal mental status examination. This allegation was not proven because, at hearing, the page of D.L.'s record containing the formal mental status examination was provided by respondent.

RESPONDENT'S EVIDENCE

35. The focus of respondent's testimony was on his examination of D.L. It appeared from his testimony, however, that he believed his documentation in D.L.'s chart was adequate.

EXPERT OPINIONS AND ULTIMATE FINDINGS RE DOCUMENTATION ERRORS

36. Dr. Harrison opined that portions of respondent's documentation on the psychiatric evaluation were illegible, and in some instances they were also incomplete in that respondent did not document how D.L.'s pants "came down." While Dr. Harrison found respondent's documentation of D.L. deficient, she did not definitively state that respondent's chart entries for D.L. were outside of the standard of care.

37. Dr. Chuang noted that the standard of care requires that physicians maintain legible and accurate medical records. For psychiatrists, notes must include a patient's symptomatology, a mental status exam, a current treatment plan and rationale for making any treatment changes. The mental status exam is an important piece of a psychiatric evaluation in that it documents observable behavior, including speech, affect, mood, thought process and content, cognition, judgment and insight. Dr. Chuang found that respondent's documentation in connection with his psychiatric evaluation for D.L. was inadequate and insufficient and was a simple departure from the standard of care because portions of the notes are not legible; respondent did not complete the form documenting his mental status exam; and because respondent failed to document the circumstances surrounding his testicular exam of D.L.

Dr. Chuang also thought that if D.L. lowered his pants without being asked to do so, as respondent claimed in his interview with the Medical Board, it would have been important to document such behavior, which Dr. Chuang regarded as impulsive and provocative, and potentially relevant to respondent's diagnosis of bipolar disorder. Dr. Chuang also observed that he would not expect a psychiatrist to continue with a testicular examination after a patient spontaneously dropped his pants. Dr. Chuang also thought that respondent should have documented comments made by D.L. that made him very uncomfortable.

38. Dr. Rosenberg did not believe that respondent's chart notes were incomplete, but he agreed that portions of respondent's handwritten medical records for D.L. were difficult to read. Even if respondent's records were inadequate, Dr. Rosenberg opined that this transgression would only constitute a simple departure from the standard of care.

39. Dr. Bloch opined that while some entries in respondent's handwritten medical records for D.L. were difficult to read, and his notes were sometimes incomplete, respondent's record keeping was not outside of the standard of care applicable to what is expected of psychiatrists. Dr. Bloch thought that respondent's notes were sufficient to allow another psychiatrist to assume treatment of D.L.

40. The testimony of Dr. Bloch to the effect that respondent's handwritten notes were not so deficient as to constitute a failure to maintain adequate and accurate records and a departure from the standard of care was not persuasive. Instead, the persuasive testimony of Dr. Chuang, established that respondent's medical notes for D.L. were inadequate and inaccurate and constituted a simple departure from the standard of care.

Palpation of L.W.'s left inguinal lymph nodes

COMPLAINANT'S EVIDENCE

41. L.W. was 23 years old, had a history of schizophrenia and methamphetamine and cannabis use, and was homeless. L.W. came to Casa Phoenix following his discharge from the Kaiser Emergency Department. His mother had brought him to Kaiser for emergency treatment for a wound on his left toe.

42. On March 26, 2016, respondent performed a psychiatric evaluation of L.W. at Casa Phoenix. In L.W.'s records, under the section entitled focused physical exam, respondent notes: left big toe injury, already seen at the Emergency Department.

43. During his psychiatric evaluation, respondent palpated L.W.'s left inguinal lymph nodes[9] over L.W.'s clothing. Respondent made a note in the past medical history: no lymph node enlargement. During his telephone interview with Dr. Harrison several days after the incident, respondent stated that he palpated L.W.'s left inguinal nodes because L.W.'s toe looked "red and very bad," and he wanted to assess whether the toe was infected and required urgent care.

RESPONDENT'S EVIDENCE

44. When respondent met L.W., he noticed that L.W. was barefooted, he walked with a limp, his feet were dirty, and he had a bloody bandage on his left toe. Respondent testified that L.W. "appeared flushed," but did not note this in L.W.'s chart. Respondent did not see the presence of red striations on L.W.'s lower left limb. Respondent performed an inguinal node inspection over L.W.'s clothes to assess whether L.W.'s toe might be infected and rule out sepsis.

EXPERTS' OPINIONS AND ULTIMATE FINDINGS RE PALPATION OF LEFT INGUINAL AREA

45. Dr. Harrison opined that respondent's examination of L.W.'s inguinal lymph nodes was an egregious violation of the standard of practice. If respondent was concerned that L.W.'s toe injury was infected and presented a risk of sepsis, he should have sent L.W. to urgent care or back to the emergency room for treatment. As a Kaiser patient, these resources were readily available to L.W. Respondent's examination of L.W.'s inguinal nodes was not only outside of the standard of care, it was also medically unnecessary

[9] Inguinal lymph nodes are located in the groin.

because if L.W.'s inguinal nodes were enlarged as a result of a toe infection there would be visible signs of the infection on L.W.'s toe and leg. Respondent's inguinal exam was also ineffective because one cannot perform an inguinal exam over a patient's clothing; the physician has to palpate the bare node to determine if it is enlarged.

46. Dr. Chuang opined that there is no psychiatric indication for performing an inguinal lymph node exam on a patient; it is a boundary violation and it has the potential to provoke psychological distress on the part of the patient. If respondent believed there was an emergency, and possibly sepsis, respondent should have sent L.W. to the emergency room to allow him to be examined by a physician who is qualified to make that assessment. Dr. Chuang concluded that respondent committed an extreme departure from the standard of care when he performed an inguinal lymph node exam on L.W. Even if respondent believed that he was authorized or required by his job duties to perform an inguinal lymph node exam, such authority or requirement does not abrogate respondent's duty, as a psychiatrist, to act within the standard of care.

47. Dr. Rosenberg opined that respondent's examination of L.W.'s left inguinal nodes was appropriate and necessary, given L.W.'s clinical presentation. Dr. Rosenberg maintained that respondent's exam was appropriate because he was looking for signs of a spreading wound infection, such as heat, red streaks appearing from wound, and swelling; he acknowledged, however, that respondent's chart notes do not document the presence of these symptoms. Given the risk of infection, Dr. Rosenberg describes respondent's examination that was conducted to rule out a serious infection, as within the standard of care and "commendable."

48. Dr. Bloch found that respondent's examination of L.W.'s left inguinal nodes was appropriate and within the standard of care because respondent was the only physician at the facility and was responsible for triaging patients. Additionally, respondent was not conducting therapy with L.W. Dr. Bloch described respondent's examination of L.W. as so thorough, that "in a way it was commendable." In formulating his opinion, he noted that the exam was "both brief and adequate to resolve the patient's acute anxiety about a potentially serious medical problem." Dr. Bloch also postulated that "Dr. Harrison had it in for [respondent]." At the same time, Dr. Bloch acknowledged that there were no notes in L.W.'s records documenting the existence of swelling, redness, heat, and/or red streaks emanating from the sight of the wound, or that he suffered from an altered mental state, or low blood pressure or respiratory rate, which are all signs of a serious infection.

49. The opinions of Dr. Bloch and Dr. Rosenberg regarding the necessity of respondent's exam are not persuasive. They presume an urgent clinical presentation on the part of L.W. and the absence of available medical care available to L.W. Neither presumption is correct. Additionally, Dr. Bloch's assumption that L.W. experienced "acute anxiety" about the possibility of sepsis is not supported by the record. L.W. had just received emergency care for his toe and had been treated and released. Additionally, in respondent's interview with Dr. Harrison, he did not maintain that he performed the exam to quell L.W.'s acute anxiety about

his toe; rather, he maintained he decided to perform the inguinal exam because L.W.'s toe looked "red and very bad," and he wanted to be sure that the infection had not spread.

50. The opinions by Dr. Harrison and Dr. Chuang that respondent committed a serious breach of care when he performed an exam on L.W.'s left inguinal node were persuasive. As these experts noted, the exam constituted a boundary violation; it was medically unnecessary, given that L.W.'s toe had just been treated in the emergency room; there was an absence of other clinical indications of a systemic infection; and urgent and emergency treatment was readily available to L.W. It was therefore established that respondent's examination of L.W.'s left inguinal nodes was an extreme departure from the standard of care and grossly negligent.

Sufficiency of respondent's documentation in L.W.'s medical records

COMPLAINANT'S EVIDENCE

51. Complainant contends that respondent's chart notes in connection with his psychiatric evaluation of L.W. are inadequate and inaccurate because respondent's handwriting is barely legible in a number of places. In other places, described below, his documentation is incomplete. Respondent did not clearly document his examination of L.W.'s inguinal nodes in the medical records. A note in the past medical history section of respondent's psychiatric evaluation states "no lymph node enlargement," but it does not identify which node was examined. Respondent did not complete the mental status exam checklist included in the psychiatric evaluation, but he did make a few handwritten notes that L.W. 'worried a lot," was "very unkempt, [had] very poor impulses, and was not suicidal or homicidal." Respondent also did not document the symptoms associated with schizophrenia, such as the presence of a disordered thought process and/or psychotic symptoms such as hallucinations or delusions.

RESPONDENT'S EVIDENCE

52. The focus of respondent's testimony was on his examination of L.W. It appeared from his testimony, however, that he believed his documentation in L.W.'s chart was adequate.

EXPERT OPINIONS AND ULTIMATE FINDINGS RE DOCUMENTATION ERRORS

53. Dr. Harrison opined that respondent's notations in the psychiatric evaluation of L.W. were incomplete and below the standard of care because the notes did not provide sufficient information to allow another psychiatrist who might take over treatment of L.W. to formulate a treatment plan.

54. Dr. Chuang opined that respondent's documentation in connection with his psychiatric evaluation of L.W. was inadequate and inaccurate because portions of it were illegible, and respondent did not complete the form documenting his mental status exam.

Additionally, respondent's documentation of L.W.'s mental status examination does not contain information relevant to L.W.'s diagnosis of schizophrenia, such as abnormalities in L.W.'s thought process or psychotic symptoms, hallucinations, or delusions. Respondent's notes do not identify which inguinal node was examined. In Dr. Chuang's view, this lack of documentation constitutes a simple departure from the standard of care.

55. Dr. Rosenberg opined that respondent's medical records for L.W. were difficult to read. To the extent that respondent's notes are inadequate, this transgression would only constitute a simple departure from the standard of care.

56. Dr. Bloch opined that while portions of respondent's notations were difficult to read and sometimes incomplete, respondent's record keeping was not outside of the standard of care applicable to what is expected of psychiatrists. Dr. Bloch thought that respondent's notes were sufficient to allow another psychiatrist to assume treatment of L.W.

57. The testimony of Dr. Bloch to the effect that respondent's handwritten notes were not so deficient as to constitute a failure to maintain adequate and accurate records and a departure from the standard of care was not persuasive. Instead, the persuasive testimony of the Medical Board's experts, established that respondent's medical notes for L.W. were inadequate and inaccurate and constituted a simple departure from the standard of care.

Credibility finding

58. Respondent's testimony at hearing and to the Medical Board lacked credibility and candor on several key points. For example, respondent testified and told the Medical Board, that D.L. dropped his pants spontaneously, and that he examined D.L.'s left testicle with a glove. This testimony contradicts respondent's statements to Dr. Harrison that he told D.L. to lower his pants, and that he performed the examination with a tissue and not a glove. Respondent's statements to Dr. Harrison are found to be credible because they were made several days after the incident and because they are also consistent with D.L.'s written statements. Respondent also testified that he performed the testicular exam on D.L. in response to D.L.'s complaint about a cyst on his left testicle. This statement does not square with respondent's statement to Dr. Harrison that D.L. mentioned the lump after D.L. had lowered his pants and was performing a self-exam. It is also hard to believe that D.L. expressed agitation about his testicular lump when there is no such documentation in the medical records, and because D.L. had deferred a genital exam when he had a physical examination just 10 days earlier.

LEGAL CONCLUSIONS

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. A licensee may be subject to discipline for violating the Medical Practice Act (Bus. & Prof. Code, § 2234, subd. (a)), or for

committing gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)),[10] or for failing to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

Cause for discipline

2. By reason of the matters set forth in Factual Findings 33 and 50, the evidence established that respondent was grossly negligent when he performed a testicular examination of D.L., and an examination of L.W.'s inguinal nodes. Additionally, by reason of the matters set forth in Factual Findings 40 and 57, respondent failed to maintain adequate and accurate medical records for D.L. and L.W.; and because his record-keeping for these two patients fell below the standard of care, these errors also constituted repeated acts of negligence. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivisions (b) and (c), and Business and Professions Code section 2266, in conjunction with Business and Professions Code section 2234, subdivision (a).

Disciplinary determination

3. As cause for discipline has been established, the appropriate level of discipline must be determined. The Medical Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) (12th ed., 2016) recommend, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's unprofessional conduct. The maximum discipline is revocation. Complainant argues that revocation of respondent's Certificate is necessary to protect the public. Respondent contends that he did nothing wrong, and should instead be commended for his treatment of underserved populations.[11]

In determining whether or not a licensee is sufficiently rehabilitated to justify continued licensure, it must be kept in mind that, in exercising its licensing functions, protection of the public is the highest priority of the Medical Board. The Medical Board seeks to ensure that licensees will, among other things, be completely candid and worthy of the responsibilities they bear by reason of their licensure. The outcome of this case, therefore, turns on whether respondent has taken responsibility for his misconduct and taken steps to rehabilitate himself to the extent that he can be trusted to practice medicine in a manner consistent with public safety.

At the outset of this analysis, it is noted that respondent has practiced psychiatry for many years and has not been previously disciplined by the Medical Board. Respondent's misconduct in the instant case, however, is egregious, and is exacerbated by the presence of

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[10] Under the language of the statute, in order to be repeated there must be two or more separate and distinct negligent acts. (Bus. & Prof. Code, § 2234, subd. (c).)

[11] Respondent alluded to being willing to take a medical record keeping course.

aggravating factors. Under these circumstances, in order to remain licensed, respondent must make a particularly strong showing of rehabilitation.

In this case, respondent examined one patient's testicle and another patient's inguinal lymph nodes.[12] This conduct constituted an egregious breach of the standard of care, and as Dr. Chuang noted, was fraught with sexual overtones, particularly to D.L., who had a history of sexual trauma and prostitution. Dr. Chuang's concern that respondent's examination could cause psychiatric distress in D.L. was well-placed. Indeed, in his complaint to Anka, D.L. wrote that respondent was "using his doctor's name to feel up patients." In addition to presenting a risk of harm to his patients, respondent's examinations cannot be justified by compelling clinical presentations; and, there were ample resources available to attend to the patients' medical conditions, ranging from the Kaiser advice nurse to urgent or emergency care.

Respondent failed to take any responsibility for, and lacks insight into, his misconduct. He continues to maintain that his examinations of D.L and L.W. were necessary in order to rule out more acute conditions, but the evidence failed to support his claims. He attempted to deflect responsibility by claiming that D.L. spontaneously lowered his pants, when the evidence established that respondent instructed him to do so. Respondent also suggests that Dr. Harrison's testimony should be discounted because she is not a credible witness. No evidence supports this claim. In fact, Dr. Harrison's testimony was the most persuasive out of all of the witnesses because unlike the other experts, she was intimately familiar with the setting in which respondent worked and that Kaiser resources were readily available to Casa Phoenix patients. Contrary to respondent's claims, the evidence established that Dr. Harrison conducted her investigation in a painstaking manner because she was keenly aware that her findings might adversely impact respondent. Respondent's misconduct is further aggravated by his dishonesty at hearing and to the Medical Board, and because his patients were extremely vulnerable.

As the California Supreme Court has observed, "Fully acknowledging the wrongfulness of [one's] actions is an essential step towards rehabilitation." (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.) In the instant case, respondent's wholesale denial of his misconduct does not reflect well on his suitability for probation. Because respondent failed to present any evidence of rehabilitation; and in light of respondent's lack of candor with the Medical Board and at hearing, the Medical Board lacks assurances that, if placed on probation, respondent can be trusted to perform licensed activities in a manner consistent with public safety. Against this background, protection of the public requires revocation of respondent's Certificate.

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[12] Respondent also failed to maintain adequate and accurate records but this violation pales in comparison to his acts of gross negligence.

ORDER

Physician's and Surgeon's Certificate No. A 728025, issued to respondent Khurram Khan Durrani, M.D., is revoked.

DATED: July 12, 2018

DocuSigned by:
Diane Schneider
[illegible]

DIANE SCHNEIDER
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Khurram Khan Durrani, M.D.** **Valley Community Counseling Services** **19 E. 6th Street** **Tracy, CA 95376-4107** **Physician's and Surgeon's Certificate No. A 72805,** Respondent.	Case No. 800-2016-021897 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 10, 2000, the Medical Board issued Physician's and Surgeon's Certificate Number A 72805 to Khurram Khan Durrani, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states, in pertinent part:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

". . . ."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2234 of the Code, states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . . ."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTS

8. At all times relevant to this matter, Respondent was licensed and practicing medicine in California. Respondent provided psychiatric services to residential patients as an independent contractor for a non-profit organization.

PATIENT D.L.[1]

9. On or about March 25, 2016, Respondent performed a psychiatric evaluation of Patient D.L., a 21 year old man.

10. Respondent reported that, during his evaluation, he described to D.L. how to conduct a testicular exam on himself and that, after his description, D.L. spontaneously lowered his pants and told Respondent that he had found a lump on his left testicle.

[1] The patients are designated in this document as Patients D.L. and L.W. to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

11. Respondent examined the lump with his thumb and forefinger and described it in his notes as a probable sebaceous cyst on D.L.'s left testicle. He did not document that D.L. had lowered his pants without being instructed to do so.

12. Respondent stated that D.L. made him feel "very uncomfortable," referring to Respondent as "Bro" and "Dude" and making comments such as "Man, nice car." Respondent did not document this conduct in his notes.

13. Respondent's chart notes for D.L.'s psychiatric evaluation consist of a standardized form which he filled in by hand. Respondent's handwriting is barely legible in places and quite difficult to read with certainty. Respondent's chart notes for D.L. do not include a formal mental status exam.

PATIENT L.W.

14. On or about March 26, 2016, Respondent performed a psychiatric evaluation of Patient L.W., a 23 year old man.

15. Respondent reported that L.W. was limping when he came in for his evaluation and had a dirty bandage on his left toe. Respondent stated that he was concerned that L.W. might have an infection or sepsis and, to find out if his inguinal lymph nodes were enlarged, asked L.W. if he had any lumps in the left inguinal region. When L.W. said that he didn't know, Respondent palpated L.W.'s left inguinal area through his clothing and determined that his lymph nodes were not enlarged.

16. Respondent's chart notes for L.W.'s psychiatric evaluation consist of a standardized form which he filled in by hand. Respondent's handwriting is barely legible in places and quite difficult to read with certainty.

17. L.W. had a previous diagnosis of schizophrenia. Although this condition is often characterized by a disordered thought process and/or psychotic symptoms such as hallucinations or delusions, Respondent did not note the presence or absence of such findings.

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CAUSE FOR DISCIPLINE

(Inadequate Documentation; Repeated Negligent Acts; Gross Negligence)

18. Respondent Khurram Khan Durrani, M.D. is subject to disciplinary action under section 2234, subdivisions (a) (violating Medical Practice Act), (b) (gross negligence), and/or (c) (repeated negligent acts), and/or section 2266 (inadequate records) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent failed to maintain appropriate professional boundaries with Patient D.L. by performing a testicular examination on him.

B. Respondent failed to maintain appropriate professional boundaries with Patient L.W. by performing an inguinal lymph node examination on him.

C. Respondent failed to provide consistently legible entries and failed to include a full mental status examination in his psychiatric evaluation notes for Patients D.L. and L.W.

D. Respondent failed to include documentation of D.L.'s alleged spontaneous disrobing and the provocative language later described by Respondent.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 72805, issued to Khurram Khan Durrani, M.D.;

2. Revoking, suspending or denying approval of Khurram Khan Durrani, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Khurram Khan Durrani, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED: May 17, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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